ANALYTICAL AND BIBLIOGRAPHICAL NOTICES.

ART. XV.—*Guy's Hospital Reports.* Edited by C. HILTON FAGGE, M.D., and ARTHUR E. DURHAM. Third series. Vol. XVIII. 8vo. pp. xviii., 502. London: J. & A. Churchill, 1873.

THE contents of the present volume of this valuable series equal in variety and interest those of its many predecessors. Among the contributors to it are Drs. Wilks, Moxon, Hilton Fagge, and Habershon, and Messrs. Cooper Forster and Bader, all of whom are well known as writers. In accordance with our custom, we shall lay before our readers abstracts of the most important papers, and shall first call attention to those on medical subjects.

On Acute Dilatation of the Stomach; by C. HILTON FAGGE, M.D.—Although chronic dilatation of the stomach, whether dependent or not upon obstruction at the pylorus or in the small intestines, is a condition which has long been recognized. Dr. Fagge thinks that up to the present time its physical diagnosis has not been carefully studied. It would be a great mistake, he says, to suppose that an enlarged stomach differs from the healthy organ, simply in occupying a larger part of the abdomen. On the contrary, a constant feature of these cases is that the organ is greatly displaced downwards; the gastro-hepatic omentum, the lesser curvature, and the cardiac extremity of the stomach, being all much elongated. Hence, instead of the dilated stomach forming a prominence in the epigastrium, that region is more or less deeply hollowed, whilst below the umbilicus one may observe a large rounded tympanitic swelling. But, he continues, the most distinctive feature of dilatation of the stomach in these cases, and that which enables the exact position of the organ to be most accurately determined, is afforded by the peristaltic movements of its muscular coat. These usually begin near the left costal cartilages, descend below the umbilicus, and after passing over to the right, terminate by ascending more or less towards the right hypochondrium. The movements of the small intestines, so frequently seen in cases of chronic intestinal obstruction, present very different characters; and in the transverse colon direct peristalsis would produce a wave passing from right to left, or in the reverse direction to that which has been described as belonging ordinarily to the gastric contraction. It must, however, be remembered that in both forms of disease, anti-peristaltic movements may and do occasionally take place.

Acute dilatation of the stomach, although occurring oftener than is perhaps suspected, is a very rare affection, Dr. Fagge having been able to collect only four cases. One of these he saw in consultation, another was treated by Dr. Rees in Guy's Hospital, the third is recorded in the fourth volume of the Transactions of the London Pathological Society, and the fourth is reported by Dr. Bennett in his work on the *Principles and Practice of Medicine.* The first is especially interesting, because the diagnosis was fully made, and the proper remedies applied during the life of the patient. He was a young man, eighteen years of age, of tall but spare frame, and although until fourteen days before he was seen by Dr. Fagge, he had been in the enjoyment of his usual health, he was probably not possessed of a very robust constitution. Upon examination the abdomen was found to be greatly but not uniformly distended. For while the whole of the lower part of the belly was full and rounded, and the left hypochondrium was equally so, the right hypochondrium was flat, or even slightly hollowed. The separation between the rounded and flattened region was indicated by an oblique line descending downwards and to the right from the upper part of the left hypochondrium. Every time the patient breathed, this line could be seen to descend a little. The principal symptoms were constant vomiting of a greenish liquid, as much as a pint being brought up at a time, and pain in the abdomen. There was a tendency to constipation, and to suppression of the urine. The symptoms were relieved at first, but afterwards returned in full force; the vomiting, however, again ceasing before the patient was visited by Dr. Fagge, who at once came to the conclusion, that whatever the original disease might have been, his distress was then mainly caused by dilatation of the stomach, and that this organ contained a large quantity of fluid, but was paralyzed from over-distension, and unable to rid itself of its burden. He therefore determined to use the stomach-pump and empty the stomach, feeding the patient for a few days by nutrient enemata, and in this way giving the organ complete rest. The tube of the stomach-pump was accordingly introduced, and as soon as it had entered the stomach a few ounces of fluid, similar to that previously vomited, were ejected through it with considerable force; and when the pump was put into action, seven pints more were removed. The effect of the operation upon the contour of the abdomen was very marked, and together with this there was complete relief from pain. The improvement was unfortunately only temporary, for two hours and a half later the patient died. At the autopsy the stomach was found only moderately dilated, but when it was pulled down by means of the omentum, it could be made to come considerably below the umbilicus. A little patch of lymph was discovered at one spot on the peritoneum, passing from the large bowel to the mesentery of the small intestine. During the necessary manipulations, the serous membrane gave way at this spot, and a thin fetid fluid with air exuded. This was found to come from a large cavity situated behind the ascending colon, gall-bladder, and other parts, all of which were fixed together by firm fibrous adhesions of old date. A finger passed through the pylorus went straight into this cavity, and it was at first supposed that the whole calibre of the second portion of the duodenum had sloughed away. Subsequently, it was found that the duodenum passed down on the inner side of the cavity. Besides a considerable quantity of fetid fluid, the cavity contained a large-sized slough, some inches long, apparently the remains of a mass of connective tissue. Dr. Fagge apparently attaches very little consequence to this lesion, but it is impossible to conceive that it was without an important bearing upon the result of the case.

In the other three cases the enlargement of the stomach was much more considerable. In the case reported by Dr. Rees, "when the abdomen was opened the stomach was almost the only organ visible. The stomach passed from the under surface of the diaphragm downwards as far as the pubes; an oblique line traced in this direction, was found to measure thirteen inches. The organ then bent sharply upwards to reach the under surface of the liver, where the pylorus lay in its natural position; a line traced obliquely upwards from the lower end of the other line at the symphysis pubis, measured eight and a half inches."

Dr. Fagge, from a careful study of the four cases reported in this paper, thinks the following conclusions justifiable: 1. Acute dilatation of the stomach may arise in young subjects, in whom that organ has previously been apparently healthy. The actual progress of enlargement is more or less gradual; but it produces at first no symptoms, and when these occur they are hidden in their onset, and of great severity, and may destroy life in a few days. Acute dilatation of the stomach may be the only disease found in the body after death, as it may have supervened upon some other morbid change in the alimentary canal. 2. Its signs are, (*a*) a rapidly increasing distension of the abdomen, which is unsymmetrical; the left hypochondrium being full, while the right hypochondrium is comparatively flattened; (*b*) The existence of a surface-marking descending obliquely towards the umbilicus from the left hypochondrium, and corresponding to the dropped-down lesser curvature of the stomach, this line appearing to descend with each act of inspiration; (*c*) The presence of fluctuation in the lower part of the abdomen; (*d*) The occurrence of splashing when the distended part is manipulated; (*e*) The presence of an uniformly tympanitic note over a large part of the distended region when the patient lies on his back. Above the pubes, on the other hand, there may be dulness on percussion simulating that of a distended bladder. 3. Its symptoms are those of severe abdominal disease, without evidence of peritonitis or lesion of the intestines. There is very profuse vomiting, so that several quarts may be evacuated in the twenty-four hours. After a time, however, vomiting may cease entirely, the stomach being paralyzed, and unable to rid itself of its contents. There is no absolute constipation, although the bowels may be more or less confined. The urine is scanty. 4. After the removal of the stomach from the body, and the escape of its contents, it may shrink back to its natural size, no matter how great its previous enlargement, and the only remaining indication that it had undergone extreme distension, may be the presence of slight lacerations of its coats.

The treatment which he recommends is that which he adopted in the case which has been so fully referred to in this notice.

In the case reported by Dr. Bennett, the patient a few days before his death swallowed two or three bottlefuls of effervescing lemonade, and the dilatation of the stomach was believed to have arisen from the sudden disengagement of a large quantity of gas. No cause is assigned for the occurrence of the condition in the other three cases. In two of the cases sarcinæ were discovered in the matter vomited in greater or less number. In both these instances numerous ecchymoses were found in the mucous membrane of the stomach, a fact of some interest as bearing upon the opinion lately advanced, that, instead of being vegetable organisms, sarcinæ arise from aggregations of blood disease.

A Case of Patent Ductus Arteriosus; by C. Hilton Fagge, M.D.—In volume sixteen of the present series of these Reports, Dr. Fagge describes a case in which a murmur was audible different in character from any bruit he had ever before heard. Two views as to its cause suggested themselves to his mind—one that it was due to a communication between the aorta and the pulmonary artery; the other, that it was a modification of an auricular systolic murmur. Last year the patient returned to the hospital and died there. On post-mortem examination it was found, that the only lesion to which the peculiar bruit could be attributed was a patent ductus arteriosus. The peculiar features in the case were extreme slowness of the pulse, and the presence of a wavy, partly musical murmur, audible at the second left costal cartilage, extending considerably to the left of the sternum along the cartilage, not carried along the sternum downwards, following the second sound, but not everywhere continuous with it, and separated from the next first sound by a considerable interval. Very few cases are on record in which a persistent ductus arteriosus has been believed to have given rise to a murmur. In the first volume of the *Transactions of the Pathological Society of London*, a case is recorded by Dr. Babington. which is the only one mentioned by Walshe. Prof. Jaksch reports a case in the *Prager Vierteljahrschrift*, for 1862, in which there was a murmur similar to that heard in the case reported in this paper. On post-mortem examination the foramen ovale was patent, as well as the ductus arteriosus.

In some *Remarks on Diseases of the Nervous System, with Cases*, Dr. WILKS complains, that, notwithstanding the light which recent physiological investigations have thrown upon the functions of the brain and spinal cord, we continue to make use of the terms "cerebral" and "spinal" paralysis. Physiologists of the present day regard the spinal cord as consisting not only of that part of the cerebro-spinal axis situated within the vertebral column, but also of the nervous centres from which the cranial nerves take their origin, seated upon its summit. The cerebrum, or brain proper, is the large mass which covers and incloses the upper part of the spinal cord, and which receives impressions from all parts of the body, as well as from the special senses, converts these into perceptions and mental processes, and develops a volitionary power which affects the cord below and through this the body at large. Disease of the brain will indeed produce delirium or dementia, but it cannot cause paralysis, which, on the other hand, is caused by any change in the spinal cord. The only exception to this rule (and Dr. Wilks regards it as only an apparent exception) is furnished by those cases in which general arachnitis or the like has, by an interference with the volitionary power, been accompanied by a want of movement in a limb.

The author next considers the pathological connection between the nerves and cerebro-spinal centres, saying that there is every reason for believing, that, owing to the direct connection between them, a peripheral portion of the body might be affected from the centre, or, on the other hand, the centre from the periphery, entirely through nervous agency. Several cases are reported and others referred to, in which a local injury resulted in paralysis of other parts. The changes in the nervous centres and in the muscles in progressive muscular atrophy and in locomotor ataxy, are also regarded by Dr. Wilks as dependent one upon the other, although, since the pathology of both these affections is still obscure, it is impossible to say which lesion has preceded the other.

The only nervous disease having an organic cause which the author has not seen counterfeited by a functional disease is contraction or spasmodic affections of the muscle. These diseases, in his experience, constitute the most difficult to explain or to treat in the whole domain of clinical medicine. In some cases he believes them to be due to chronic spinal meningitis, in others to sclerosis of the cord itself. Dr. S. W. Mitchell, in his recent work on *Injuries of Nerves and their Consequences*, has shown that in some cases sclerosis of the nerves of the affected part may also exist. A few pages are devoted to the consideration of "Vertigo and Cerebral Symptoms occurring in Deafness and other Affections of the Ear." This subject is, however, more fully discussed by Mr. James Hinton in a paper "On Labyrinthine Vertigo; sometimes called Ménière's Disease." The paper concludes with some remarks on the Uses of Galvanism.

On Sudden Death from Syncope soon after Labour; by J. J. PHILLIPS, M.D. —There is a class of cases in which sudden death occurring soon after labour is attributed by Dr. Phillips to fatty degeneration of the heart, which has been set up by the anæmia so often attendant upon pregnancy. The patients whose histories he records were multiparæ, and are described as being pale and having the external appearances of women in feeble health. In almost every instance there was an antecedent history of breathlessness, either during gestation or labour, and whenever an opportunity of examining the heart microscopically was afforded, the muscular tissue exhibited well-marked fatty degeneration.

"This point" he says, "appears to be one deserving of special notice, and I cannot but think that it was an important factor in the production of the fatal result. I am, indeed, aware that a certain amount of fatty change in the tissue of the heart has not been here commonly noticed in cases of child-bed death; but this degeneration, even if regarded (as it has been) as simply the result of certain blood changes incident to pregnancy, must, I think, when once produced, be looked upon as having more than an accidental relation to the mode of death in these cases of fatal syncope."

The author refers to papers by De Cristoforis, Wilks, Gusserow, and Hecker, in support of his views.

In a paper *On the Dynamics of Epilepsy and Convulsions.* Mr. J. Thompson Dickson advocates the view that all excito-motor affections are the resultants of two factors—the first, loss of cerebral control; the second, an excitant. Both factors, he says, are always present in convulsions, whether the convulsion be local or general, in epilepsy and eclampsia, though the second may be so far wanting as to render the chain of symptoms, as commonly described, incomplete. The cord capable of reflecting excito-motor stimuli under certain circumstances, must be considered as extending from the united thalami optici and corpora striata to the caudal extremity of the medulla spinalis. The normal influence exerted by the cortex of the brain on the excito-motor apparatus is one of control, an influence exerted more or less through the simple agency of volition or will, which presumably is capable of controlling an impulse to most involuntary movements, such normal reflex acts as deglutition and ejaculatio seminis, whose centres of action are out of connection with the cortical gray matter, being of course excepted. The occurrence of local convulsions the author explains by supposing that the power of control (by excision, tumour, abscess, or other means of destruction of tissue) is cut off from a limited area of the brain's surface.

Mr. Dickson thinks that the proximate cause of excito-motor action is to be sought for in some alteration in the circulation of the brain, but he agrees neither with Dr. Marshall Hall, in believing that this alteration depends upon an impeded flow of venous blood from the brain, nor with Mr. Solly, in considering it to be due to an active determination of blood to the head. He holds, on the contrary, that the condition really present is cerebral anæmia. In support of this view he refers us to observations, made in slaughter-houses, where animals are put to death by bleeding, the effect of which is always to produce convulsions before death. This was at first explained by the assumption that muscles contracted spasmodically when deprived of blood, but the fallacy of this opinion has been demonstrated by Kussmaul and Tenner, who have shown that deprivation of the brain of arterial blood by tying the vessels of the neck will produce all the effects as perfectly as, or more perfectly than, depletion. This conclusion has been rendered still more certain by the study of the brain by Donders's method, which consists in inserting an air-tight window into the skull and observing the brain through it. It is then found that on compression of the large arteries of the neck complete anæmia of the brain and its membranes ensues, and this continues until the convulsion begins, when the venous anæmia partially subsides, though the arterial and capillary anæmia is unaltered. Indirect evidence in favour of the same view is furnished by the blanched anæmic appearance of the face and neck on the invasion of an epileptic attack, which must correspond with the condition within the skull. Moreover, convulsions are produced by the injection of water into the circulation.

The invasion of unconsciousness in epilepsy is always sudden, and it may be explained by supposing that under the influence of some irritant an instantaneous contraction of the smaller arterial vessels takes place. This irritant may be a tumour or an abscess seated within the cranium, or it may be contained in the blood, or may act upon the medulla spinalis from some other part of the body. The author regards the loss of consciousness which takes place in apoplexy as also caused by anæmia of the brain, the extravasated blood in this case acting as the irritant. Niemeyer has long held the view that apoplectic stupor was due to this condition, but he explains its occurrence differently.

Dr. Hughlings Jackson has recently advanced the theory that from the seat of pathological lesions discharges are sent out, which are distributed to certain muscles in the case of local affections, and to the muscles generally in the case of a general affection. Dr. Dickson maintains, on the contrary, that when control over certain muscles is lost or diminished by destruction or injury of a portion of the surface of the brain, involuntary or convulsive movements will occur in these muscles from reflex excitation. The muscles, he says, contain a power of contraction in themselves, irrespective of mandates from the cerebrum, and convulsive movements may be induced in a warm-blooded animal after the whole of the cerebrum has been sliced away.

Mr. JAMES HINTON contributes a paper *On Labyrinthine Vertigo, sometimes called Ménière's Disease.* Under the name of Ménière's disease is described a very numerous class of cases, apparently embracing several varieties, in which some of the symptoms of formidable disease of the nervous centres, especially giddiness, vomiting, and staggering, have their origin in affections of the labyrinth. In the cases comprehended under this title, the nervous symptoms do not depend upon inflammation of the tympanum or of the adjacent parts, which, it is well known, is capable of producing grave cerebral disorders, or upon the pressure caused by accumulations of cerumen or by a foreign body in the meatus which occasionally give rise to symptoms simulating those of cerebral affections. The nature of the lesion of the labyrinth in Ménière's disease is still unknown. In fact the few post-mortem examinations which have been made seem to indicate that it is not always the same. Dr. Knapp, of New York, in an exhaustive discussion,[1] has given it as his opinion that the phenomena of labyrinthine vertigo may be traced in all cases either to hemorrhage or to serous or purulent exudation within the semicircular canals. Several interesting cases of the affection will be found in this paper and others in Dr. Wilks's.

Queries in Theoretical Physiology, No. II.; by JAMES HINTON.

On the Artificial Formation of Organic Substances; by Dr. HENRY DEBUS.

These papers are of more interest to the organic chemist than to the practical physician, and in view of the limited space at our command, we shall not attempt to analyze them.

A Case of Inflammation of the Aorta, causing Contraction of its Ascending Part and Fatal Ischæmia; by WALTER MOXON, M.D.—Three patches of disease of the aorta were found in this case—one situated at the origin of the vessel, another in the commencement of the descending part, and the third near the cœliac axis. These patches are said to have had the appearance of a circumscribed eruption, with a tendency to spread with convex edges just like a patch of lupus. The thickness of the diseased part was considerably increased, so that it was five times that of the healthy portions of the vessel, but not uniformly so. A microscopic examination showed that the cells, of which certain yellow spots in the patches were made up, were exceedingly small ($\frac{1}{5000}$ of an inch), and have some resemblance to those of tubercle. Dr. Moxon believes that the disease was originally eruptive, in the sense in which we speak of cutaneous eruptions, and from this and other cases which he has met he is emboldened to express his belief that the coats of the arteries are as liable to inflammatory eruptions as the skin to its eruptive inflammations.

---

[1] "Archives of Ophthalmology and Otology," vol. ii. No. 1, p. 204.

In a paper *On Hospital Dietaries*, Dr. J. C. Steele compares the diet-tables of the various hospitals in London, not only with one another, but also with those of some of the provincial hospitals. He has evidently fully investigated the merits of each, and we would commend the careful study of the article to those who may be in charge of similar institutions in this country, where we have good reason to believe the diet of the sick is not nearly so well attended to as its importance demands.

Some Cases of Hydatid Disease; by S. O. Habershon, M.D.—In the *Hospital Reports* for 1860, Dr. Habershon published several cases of hydatid disease. In this volume he places on record four additional instances, because, he says, they illustrate some of the difficulties in diagnosis, and because they show the importance of early and decided treatment when the nature of the malady is ascertained. In the first case the hydatid appeared to have located itself originally in the lung, where it seems to have given rise to so much irritation as to have caused hemorrhages. During one of these a portion of membrane was expectorated, in which Dr. Moxon detected the plicated foldings of a hydatid cyst. Death in this case was caused by hemorrhage from a vein which opened directly into the cavity left by the hydatid, a lesion which is very well shown in the accompanying plate. The result was more fortunate in the next instance, in which the hydatid cyst was also expectorated. The symptoms indicated that the disease was originally seated in the liver, that adhesive inflammation on both sides of the diaphragm had taken place, and that the cyst had then made its way into the lung. The diagnosis in the third case was more difficult, for even after the hydatid character of the disease was recognized, it was doubtful whether the mischief was located in the kidneys or in the spleen or in the left lobe of the liver. The tumour extended too far into the left loin and into the left hypochondriac region for it to be the left lobe of the liver, but it was more difficult to ascertain whether the kidney or the spleen was affected. The cyst was twice punctured by Mr. Bryant, who drew off on the first occasion thirty-seven ounces of a clear fluid free from albumen, in which Dr. Fagge detected the head of an echinococcus surrounded by a row of hooklets. At the second operation five pints of fluid also containing scolices were removed. A small number of hydatid cysts also came through the canula. The cyst was subsequently washed out with a dilute solution of carbolic acid (2 grains to 4 ounces). The patient finally sank from exhaustion induced by rupture of the sac into the peritoneal cavity. In the last case there was an old hydatid cyst in the liver, which induced perforation of the diaphragm and subsequent pleurisy and death.

The unfavourable termination of most of the instances recorded in this paper, induces Dr. Habershon to believe that if the diagnosis be clear it is a safer plan to withdraw the fluid early than to trust to the possible death of the hydatid and gradual wasting of the cyst, and in cases also where there is a refilling of the cyst after tapping he regards it as the wiser plan to re-empty the cyst early than to allow suppurative changes to ensue by the indefinite postponement of a second operation. J. H. H.

Turning our attention now to those papers which are more particularly interesting to surgeons, we meet first with Mr. J. COOPER FORSTER's annual contribution of *Clinical Records*. In the present instalment. Mr. Forster has wisely limited his selection to the more important cases which have been under his care, giving the details of but sixty-three out of nearly four hundred. He has also much increased the value of his pages by adding a synopsis arranged as an index, by means of which reference is easily made to the somewhat miscellaneous contents of his paper. Among Mr. Forster's most interesting cases we note particularly one of innominate aneurism, unsuccessfully treated by distal pressure on the carotid—the patient dying on the sixth day from capillary cerebral hemorrhage; and one of naso-pharyngeal polypus, the removal of which was facilitated by a preliminary osteo-plastic resection of the upper jaw, the bone being displaced *outwards*, instead of inwards, as in Langenbeck's, or downwards, as in Cheever's operation. From Mr. Forster's remarks upon Prof. Lister's "antiseptic method," we select the following paragraphs, which afford what we are disposed to consider a very just estimate of this much-vaunted mode of treatment:—

> "During the past year I have tried the antiseptic treatment in many cases in which I thought it could be carried out satisfactorily. . . . To insure the thorough application of this method necessitates the constant attention of the surgeon who has charge of the case, and practically, in a London Hospital, such entire supervision is a simple impossibility. The practice, therefore, becomes virtually placed in the hands of the dressers, and unless these gentlemen take a great interest in improvements, or are not too much occupied with the many cases which almost overburden them during their respective weeks of duty, it is not likely to be taken up warmly by them. Moreover, the thorough method of the application of the dressing is not acquired without considerable practice, and when acquired one's best efforts are often rendered futile by the restlessness of the patients. Hence the measure of my success during the last year has not been what I had hoped for. . . . Whether or not the absence of pyæmia and erysipelas from the wards has been due to the carbolic vapour permeating them, or to the application of the acid directly to discharging surfaces, of course I cannot speak positively, but my impression is that carbolic acid, in whatever form, has had very little to do with the results obtained, and that those curses of surgical practice (erysipelas and pyæmia) have been avoided by greater cleanliness in the wards, and the larger cubic area allowed to each patient. That this immunity cannot be owing to the antiseptic treatment must, I think, be evident from the fact that none of my surgical colleagues, who have charge of the other wards, have used this antiseptic plan, and there has been in their case an equal immunity from erysipelas and pyæmia. . . . Isolated cases of wonderful results, under antiseptic means, are to be met with now and then, but whether on account of, or notwithstanding, the treatment, appears to me to be quite impossible to determine. . . . If the remedy . . . is only available in practised hands, I cannot think it advisable to teach students that it is the one plan of treating all cases of external wounds. My results do not even bear me out in telling them that it is the most advisable treatment to be adopted; it is impossible to compare case with case. In the only very severe accident in which I tried the plan myself, taking every precaution that possibly could be adopted to insure the treatment being carried out in its entirety, I utterly failed to secure a good result."

The next paper to which we shall invite our readers' attention is *On Follicular Disease of the Scalp;* by JAMES F. GOODHART, M.B.

The author refers to papers on follicular disease, by Messrs. Cock and

Birkett, in a previous volume of the *Guy's*,[1] and by Mr. Prescott Hewett, in the *St. George's Hospital Reports*,[2] and then, dismissing the clinical features of the affection, gives an account of the microscopic appearances observed in two cases under the care of the late Mr. Poland, and compares them with the appearances in a third case, published by Mr. Birkett in the *Transactions of the Pathological Society of London*, and with those in a fourth, known as Chassaignac's and quoted by Mr. Hewett in the paper already referred to. While in their general characteristics the growths in these four cases presented a tolerably complete correspondence with each other, their microscopic peculiarities differed, the first (and probably the last) being of an epithelial character, the second sarcomatous, and the third resembling a gland in its cellular elements. We have not space to follow Mr. Goodhart in his interesting discussion of the different views which have prevailed as to the origin and nature of these follicular tumours or sebaceous cysts, but must content ourselves with transscribing the paragraphs in which he gives a "summary" of what has gone before:—

> "There seems to be enough evidence to show, first, that follicular tumours are, in their bare anatomical details, suspicious in their tendencies, and that, inasmuch as their anatomy is an index, rough though it may be, of their life's process, that is to say, of their pathology, from the latter point of view they may still be said to have very close relations to the cancerous or malignant group.
>
> "Secondly, abundant material is at hand to prove, as former writers on the subject have shown, that, clinically, such tumours have not the behaviour of cancers, and if removed they do not return. Pathology and surgery in its clinical aspect would seem at first sight, then, to come into collision; they do not do so in reality. The non-recurrence of the tumour only shows that the regions more especially prone to attack afford opportunities for their complete extirpation, or that allowing of growth which is malignant in its nature, the local peculiarities of the part have been in some way inimical to the extension of the disease.
>
> "It seems almost unnecessary to add that the practice urged by Mr. Cock, in his paper on the subject, as to the advisability of the early removal of the tumour, is very strongly supported by these observations."

Mr. Goodhart's paper is illustrated with two well-executed plates.

The next surgical paper is a *Note on the Operation of Circumcision in the Adult;* by H. G. Howse, M.S. Mr. Howse calls attention to the fact that after the operation of circumcision, as ordinarily performed, a considerable swelling, resulting from inflammatory induration, occasionally persists at the lower part of the penis. To obviate this he says:—

> "The remedy which I propose, and which I have been in the habit of using in all my circumcision cases, is the following: After removing the skin in the ordinary way, cut out the wedge-shaped piece of mucous membrane *at the frænum* with a pair of scissors, and then snip the frænum cleanly away from the glans, thus removing it and the wedge-shaped bit of mucous membrane in one piece together. Then unite the skin and the mucous membrane in the ordinary way, etc."

Upon which we have to remark that (1) the removal of the frænum with a wedge-shaped portion of the prepuce, is in effect but a revival of the old method of Taxil and Jobert (de Lamballe), and that (2) it has the disadvantage of exposing the patient to the risk of secondary hemorrhage, a complication which we have ourselves met with in a case of circumcision in which the frænum was divided at rather a higher point than usual. As to the deformity, to which Mr. Howse justly objects, we believe that it is much less apt to follow the operation of *circumcision* than that of simple *division* of the prepuce on its dorsal aspect, which some surgeons, for reasons which we have never been able to understand, seem to prefer.

---

[1] Guy's Hosp. Reports, 2d S., vol. viii.

[2] St. George's Hosp. Reports, vol. iv. p. 91, and No. of this Journal for July, 1870, p. 208.

We come next to *A Description of the Appearances of the Human Eye in Health and Disease as seen by the Ophthalmoscope. Seventh Series. Myopia; Region of the Yellow Spot.* By C. BADER. This short paper, which is a continuation of the author's previous contributions under the same general title, is accompanied with a chromo-lithographic plate containing five figures.

The next is at once one of the longest and one of the most valuable papers in the whole volume; it forms, indeed, one of the most important contributions to the literature of its subject with which we are acquainted. At the same time, candor compels us to add that it will prove, we fear, in a great degree "caviare to the general," and that it is not most appropriately placed in a volume of hospital reports. The paper in question is by Dr. WALTER MOXON, and is *On the Pathological Nature of Tumours.* We have read the whole of Dr. Moxon's essay with much interest, and would cordially commend it to the attention of such of our readers as take pleasure in studying the obscure but important subject of morbid growths; we must content ourselves, however, in this place, with quoting the author's conclusions, which are as follows:—

"*Summary of the theory of tumours.*—In the present state of our knowledge of tumours, both benignant and malignant, it is necessary to regard the hæmal processes as subordinate to the parenchymatous processes in their production.

"The blood furnishes a plasma to the tumour, and very likely favours the development of the tumour much in the same way as starvation in a plant favours the development of the aphis. Such favouring tendency in the blood may be necessary, but is not sufficient to form a tumour.

"The power of the blood-cells to form tumours in leukæmia, etc., if proved, is only a means of secondary causation, because the blood-cells themselves are derived from the solid textures. There is no reason to believe that the 'plasma' furnished by the blood can produce cells.

"The individual cell-elements of tumours arise by multiplication of the cell-elements of the parenchyma. This multiplication of the parenchyma-cells is always constitutional, although it be localised in the part, and although it may require prolonged irritation to elicit its activity. There is also a 'higher' controlling influence to be recognised in the formation of tumours—an influence equal to that which governs the organization of the several organs of the normal anatomy. This organizing influence determines the elementary cells into various plans according to the nature of the tumour."

Dr. Moxon's essay is illustrated with well-executed wood-cuts, showing the microscopic appearances of the various forms of tumour described by modern pathologists.

The next paper to be considered is called *Notes of Abnormalities observed in the Dissecting-Room, from October*, 1870, *to June*, 1872; by N. DAVIES-COLLEY, M.C., F. TAYLOR, M.D., and B. N. DALTON, M.B. The amount of anatomical work done by the students of Guy's Hospital may be estimated from the statement that no less than 160 subjects were dissected from October, 1870, to June, 1872. Abnormal arrangements of muscles, arteries, nerves, etc., were observed in many instances, and the more important variations are here enumerated, and will be referred to with interest by those who are engaged in the study of anatomical science.

A Case of Progressive Caseous Disease of the Lymphatic Glands after Disease of the Knee-joint, is narrated by JAMES F. GOODHART, M.B. The chief point of interest in this case was that in the left lung were numerous masses of cheesy material, which appeared to have been formed by extension of disease from the lymphatic glands at the root of the organ; the case, in the words of the author, "is one of the very few instances on record, in which, precisely as in the lower animals, a tuberculosis has extended from a local cause in a manner so direct that it cannot be questioned."

The next paper is *On Suppuration and Sphacelus of the Tooth-pulp;* by S. J. A. SALTER, M.B., F.R.S. Suppuration of the tooth-pulp is believed by Mr. Salter to be a much commoner occurrence than is ordinarily supposed; he has so frequently found pus in small quantities in the pulps of comparatively healthy teeth, which have given rise to very moderate symptoms, that he is convinced that suppuration often exists without being suspected, the tooth recovering from its painful condition, and subsequently remaining as a useful and apparently a sound organ. With regard to the source of the pus in these cases, he adds—

> "It has appeared to me that the pus in the tooth-pulp is formed at the expense and by the multiplication of the cells (granules of Purkinje) which so largely pervade the pulp, by their direct conversion into pus-cells, just as Virchow has shown that the pus is formed in parenchymatous organs by the proliferation of the development cells of the connective tissue."

The next paper is one of much practical interest and value; it is *On some of the New Growths developed in the Breast associated with Cysts;* by JOHN BIRKETT. Nine cases are given in detail, illustrating the various forms of new growth which are met with in connection with cysts in the mammary region, and the author proposes a mode of classifying cysts of the breast, which, as it differs somewhat from the classifications commonly employed, we copy for our readers' edification.

CYSTS IN THE BREAST.	I. Associated, communicating, or connected with the ducts.	1. Milk.	
		2. Growths; with serum coagulable, and sometimes tinged with blood.	1. Adenoid. 2. Granulation cells. 3. Cancer.
	II. Not connected with the ducts.	1. Blood.	
		2. Milk.	
		3. Simple cysts. 4. Entozoon cysts.	Serum not coagulable.
		5. Growths; with serum coagulable, tinged with blood, and containing cholesterine.	1. Adenoid. 2. Granulation cells. 3. Cancer.

Mr. Birkett's paper is illustrated with two fine plates, each containing two figures.

The last papers in the volume are the *Statistical Accounts of the Patients treated in Guy's Hospital during* 1871 *and* 1872; by J. C. STEELE, M.D. These papers contain elaborate tables of diseases, injuries, operations, etc., and furnish a great deal of valuable information in a form convenient for reference. Their study forces upon us one reflection, viz., that it is a matter for regret that the large amount of practical surgery mirrored forth in these tables should be so inadequately represented in the papers contained in the body of the volume. Excellent and admirable as they may be in themselves, such papers as, for instance, Dr. Moxon's on tumours, are not what we have been in the habit of looking for in the successive volumes of *Guy's Hospital Reports.*

J. A., JR.